IN THE UNITED STATES BANKRUPTCY COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

In re: PROSPECT MEDICAL HOLDINGS, INC., *et al.*,[1] Debtors.	Chapter 11 Case No. 25-80002 (SGJ) (Jointly Administered)
PROSPECT CCMC, LLC, *et al.*,[2] Plaintiffs, v. ROBERT F. KENNEDY, JR., in his official capacity as Secretary, United States Department of Health and Human Services; and MEHMET OZ, in his official capacity as Administrator, Centers For Medicare and Medicaid Services, Defendants.	Adv. Proc. No. 25-08009 (SGJ)

DEFENDANTS' BRIEF IN SUPPORT OF THE MOTION TO DISMISS

[1] A complete list of each of the Debtors in these chapter 11 cases may be obtained on the website of the Debtors' proposed claims and noticing agent at https://omniagentsolutions.com/Prospect. The Debtors' mailing address is 3824 Hughes Ave., Culver City, CA 90232.

[2] The Plaintiffs in this adversary proceeding are Prospect Penn, LLC; Prospect Crozer, LLC; Prospect CCMC, LLC; Prospect DCMH, LLC; Prospect Crozer Urgent Care, LLC; Prospect Penn Health Club, LLC; Prospect Crozer Home Health and Hospice, LLC; Prospect Crozer Ambulatory Surgery, LLC; Prospect Health Services PA, Inc.; and Prospect Provider Group PA, LLC.

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INTRODUCTION

This case presents one simple legal issue: whether CMS may lawfully terminate a hospital's Medicare Part A provider agreement once the hospital shutters its doors and stops providing inpatient services. The unequivocal answer is yes. The Medicare Act (defined below) mandates that CMS terminate a provider's enrollment when the provider no longer qualifies as a hospital or otherwise fails to comply with all its statutory and regulatory obligations. Here, the Debtors closed their Pennsylvania hospital, Crozer-Chester Medical Center ("CCMC"), and stopped providing inpatient services as of May 2, 2025. Once CCMC stopped providing inpatient services, it no longer qualified as a Medicare provider prompting CMS to terminate CCMC's enrollment from the Medicare program effective as of June 21, 2025.

CMS' termination occurred in June because the Debtors represented to this Court and all the parties in this case that they would voluntarily terminate CCMC's Medicare provider agreement once CCMC closed its emergency department, which (again) occurred by May 2, 2025. Only after the Debtors failed to voluntarily submit CCMC's enrollment termination did CMS learn that the Debtors were using CCMC's provider number to impermissibly bill Medicare for alleged services being provided by their independent Pennsylvania ASC/Imaging Sites. The week after learning that no voluntary termination was forthcoming, CMS gave its notice of CCMC's enrollment termination based on CCMC's closure as an inpatient facility.

The undisputed fact that CCMC was no longer operating as an inpatient hospital as of May 2, 2025, is the only relevant fact to consider when reviewing the Complaint in a light most favorable to Plaintiffs. However, despite CMS' clear statutory authority to terminate CCMC's Medicare provider agreement when it did, the Debtors attempt to challenge CMS' termination

decision through this proceeding by disclosing and relying on discussions regarding their misuse of CCMC's provider number. These discussions, referred to throughout the Complaint, gloss over the real relief the Debtors seek: a retroactive adjudication under Medicare law that the Pennsylvania ASC/Imaging Sites qualify as hospital-based outpatient facilities that may have entitled them to use CCMC's provider number after CCMC was no longer operating as a hospital. Without this administrative relief (and the reinstatement of CCMC's provider agreement), the Debtors cannot bill Medicare for services provided by the Pennsylvania ASC/Imaging Sites after CCMC closed—a risk that the Debtors knowingly took when they chose not to seek a regulatory determination from CMS regarding their Pennsylvania ASC/Imaging Sites before closing CCMC.

Notwithstanding that the parties' counsel informally discussed the Debtors' self-inflicted billing predicament, CMS is still required to enforce Medicare law, including terminating providers who are no longer eligible for enrollment in the Medicare program. CMS' decision to terminate a Medicare provider agreement (and determine whether a facility qualifies as a hospital-based outpatient facility) is under the exclusive jurisdiction of the Secretary of HHS until the Debtors exhaust their administrative remedies. Therefore, this Court has no jurisdiction to declare that CMS cannot terminate a provider for failing to comply with federal law and regulations. Nor can this Court adjudicate that the Pennsylvania ASC/Imaging Sites are hospital-based outpatient facilities entitled to retroactively bill Medicare (which billings would represent any alleged damages in this case).

Thus, regardless of whether Plaintiffs' allegations are accurate or even relevant, Plaintiffs are not entitled to judicial review of CMS' termination decision—a decision upon which all requests for relief in the Complaint ultimately rely upon. Nonetheless, even if this Court did have

jurisdiction over the relief sought, CMS' decision to terminate CCMC as a Medicare provider was neither a violation of the automatic stay nor a discriminatory act by CMS based on the facts presented in the Complaint. Accordingly, this Court must dismiss the Complaint for lack of subject matter jurisdiction and for failure to state any claims upon which relief can be granted.

STANDARDS OF REVIEW

1. The relevant parts of Rule 12(b) of the Federal Rules of Civil Procedure apply to bankruptcy adversary proceedings pursuant to Rule 7012 of the Federal Rules of Bankruptcy Procedure (the "Bankruptcy Rules"). Dismissal of a complaint is appropriate under Bankruptcy Rule 7012(b)(1) when the plaintiff fails to establish jurisdiction. "The party invoking the court's bankruptcy jurisdiction has the burden of proving that jurisdiction exists." *In re Enron Corp. Sec. Deriv. & ERISA Litig.*, 2006 WL 8447802, *2 (S.D. Tex. Nov. 11, 2006). A court accepts well-pleaded factual allegations as true but is not bound to accept true "any unsupported statements [that] are merely legal conclusions masquerading as facts." *Travis v. City of Grand Prairie*, 2015 WL 13002069, at *4 (N.D. Tex. Aug. 6, 2015). The Court also may consider additional "undisputed facts evidenced in the record . . . plus the court's resolution of disputed facts" bearing on jurisdiction. *In re S. Recycling, L.L.C.,* 982 F.3d 374, 379 (5th Cir. 2020).

2. Bankruptcy Rule 7012(b)(6) provides for dismissal of a complaint that fails to state a claim upon which relief may be granted. A complaint survives a motion to dismiss under Rule 12(b)(6) only if it contains "sufficient factual matter, accepted as true, to state a claim for relief that is plausible on its face." *Inclusive Cmtys. Project, Inc. v. Lincoln Prop. Co.*, 920 F.3d 890, 899 (5th Cir. 2019). The complaint must state the "grounds" for the alleged entitlement to relief, rather than a formulaic recitation of the elements of a cause of action. *Bell Atl. Corp. v. Twombly*,

550 U.S. 544, 545 (2007). Courts routinely "strike allegations from complaints that detail settlement negotiations within the ambit of Rule 408 [of Federal Rules of Evidence]" pursuant to Rule 12(f). *Berry v. Lee*, 428 F. Supp. 2d 546, 563 (N.D. Tex. 2006).

3. Further, a court may consider documents attached to a motion to dismiss without converting the motion to a motion for summary judgment when they are referenced in the complaint and central to the plaintiff's claims. *See Causey v. Sewell Cadillac–Chevrolet, Inc.,* 394 F.3d 285, 288 (5th Cir. 2004) ("Documents that a defendant attaches to a motion to dismiss are considered part of the pleadings if they are referred to in the plaintiff's complaint and are central to her claim."; *Maloney Gaming Mgmt., LLC v. St. Tammany Parish,* 456 F. App'x 336, 341 (5th Cir. 2011) ("District court could consider items attached to defendant parish's motion to dismiss without converting motion into one for summary judgment.").

STATUTORY AND REGULATORY FRAMEWORK

I. Pertinent Statutes and Regulations Regarding the Medicare Program

4. The commonly known "Medicare Program" is a federally funded program of health insurance for the aged, the disabled, and persons suffering from end stage renal disease. 42 U.S.C. § 1395, *et seq*., (the "Medicare Act"). Congress has charged the Secretary of HHS with the responsibility for administering the Medicare Program and authorized the Secretary to issue regulations and interpretive rules implementing the statute. *See, e.g.*, 42 U.S.C. §§ 405(a), 1395hh(a), and 1395ii. The Secretary has delegated these responsibilities to CMS. *See* 55 Fed. Reg. 9363 (March 13, 1990) and 66 Fed. Reg. 35437-03 (July 5, 2001).

5. To receive payment for covered Medicare items or services, a provider must be enrolled in the Medicare program. 42 C.F.R. § 424.505. To enroll, a provider must enter and sign

a provider agreement and meet the requirements of that agreement as part of the process to obtain Medicare billing privileges. 42 C.F.R. § 424.510. Similarly, to maintain enrollment in the Medicare program, a provider must continue to comply with Title XVIII of the Medicare Act and the applicable Medicare regulations. 42 C.F.R. §§ 424.500, 424.516. A hospital may request to participate in the Medicare program, but must meet the conditions of participation, including the statutory definition of a "hospital." *Id.* at §§ 488.3(a), 489.10(a); 42 C.F.R. Part 482. "Hospital" is an institution that "is ***primarily engaged in providing*** . . . ***inpatients***" services. 42 U.S.C. § 1395x(e) (emphasis added). Hospitals participating in Medicare are defined as "providers" for Medicare program purposes. 42 U.S.C. § 1395x(u); 42 C.F.R. §§ 400.202 (defining a "provider").

II. CMS' Statutory Authority to Terminate Medicare Provider Agreements

6. 42 U.S.C. § 1395cc(b)(2), as well as 42 C.F.R. § 489.53, authorize CMS to terminate a provider agreement when CMS finds that a provider is out of compliance with federal requirements. Specifically, the Medicare Act and regulations provide three avenues for terminating a provider agreement: (i) involuntary termination by CMS (42 C.F.R. § 489.53); (ii) involuntary termination by the HHS Office of Inspector General (42 C.F.R. § 489.54); or (iii) voluntary termination by the provider (42 C.F.R. § 489.52). *See also* 42 U.S.C. § 1395cc(b) ("Termination or Nonrenewal of Agreements"). An involuntary termination is an "initial determination" subject to administrative appeal rights. *Id.* §§ 489.53(e), 498.3(b)(8); 42 U.S.C. § 1395ff(b) (providing administrative appeal rights for "initial determinations"). The Secretary may terminate a provider upon such reasonable notice to the provider. *See* 42 U.S.C. § 1395cc(b)(2) ("The Secretary may refuse to enter into an agreement under this section or, upon such reasonable notice to the provider and the public as may be specified in regulations, may refuse to renew or

may terminate such an agreement.") (emphasis added). A failure to meet the definition of a "hospital" as defined under 42 U.S.C. § 1395x(e) is one of the specified bases for which CMS may terminate a provider agreement. *See* 42 U.S.C. § 1395cc(b)(2)(B) (stating CMS can terminate a provider agreement if it "has determined that the provider fails substantially to meet the applicable provisions of section 1395x of this title[.]").

III. Medicare Administrative and Judicial Review

7. As noted by one court, the Medicare Act provides a highly "reticulated statutory scheme, which carefully details the forum and limits of review" of all claims arising under Medicare. *Row 1 Inc. v. Becerra*, 92 F.4th 1138, 1140 (D.C. Cir. 2024). The heart of that scheme is section 405 of the Social Security Act, which outlines a structure for administrative appeals and reserves jurisdiction to HHS to consider them.[3]

8. Section 405(h) channels disputes arising under the Medicare Act into the administrative review process and restricts judicial review until administrative review is complete. Section 405(h)'s second sentence explicitly commands: "No findings of fact or decision of the Commissioner of Social Security shall be reviewed by any person, tribunal, or governmental agency except as [stated in § 405(g)]." 42 U.S.C. § 405(h). Section 405(g), in turn, provides that judicial review may be obtained only after a claimant receives a "final decision of" the Secretary. 42 U.S.C. § 405(g). Pursuing relief through the administrative scheme is therefore the exclusive route to judicial review for claims arising under the Medicare Act. *See Shalala v. Illinois Council on Long Term Care, Inc.,* 529 U.S. 1, 12–14 (2000); *In re St. Johns Home Health Agency, Inc.,* 173 B.R. 238, 242–43 (Bankr. S.D. Fla. 1994) ("The second sentence of § 405(h) requires that

[3] The Medicare Act incorporates operative provisions of section 405 of the Social Security Act, including sections 405(g) and (h) discussed below, through 42 U.S.C. §§ 1395ff and 1395ii.

administrative appeal processes be exhausted before this Court or any other tribunal may review a finding or decision of the Secretary.").

9. The Medicare Act and its governing regulations provide the exclusive path for aggrieved parties to challenge CMS' decision before eventually permitting judicial review under sections 405(g) and (h). If a provider receives an initial determination by CMS, such as termination of a Medicare provider agreement, and is dissatisfied with CMS' decision, the provider must first seek administrative review before receiving "judicial review of the Secretary's final decision." 42 U.S.C. § 1395cc(h)(1)(A) ("[A]n institution . . . dissatisfied . . . shall be entitled to . . . judicial review of the Secretary's final decision after such hearing as is provided in section 405(g) of this title.").

RELEVANT STATEMENT OF FACTS

10. On March 6, 2025, the Court held a status conference regarding the potential closure of their Pennsylvania Hospitals during which the Court expressed relief that the Debtors were planning to comply with the regulatory requirements in closing the hospitals. *See* March 6, 2025, Tr., Docket No. 916 at 17:20-23, 25 and 18:1-2 ("Okay. And I'm glad you said that, because my understanding has always been there's a regulatory requirement that hospitals like these, they have a closure plan already. . . . And there's nothing about the bankruptcy process that's going to override that. There will have to an appropriate closure plan.") (attached hereto as **Exhibit A** at 18-19). Later that same day, the Debtors filed a motion to close the Pennsylvania Hospitals representing to the Court that they will "[s]ubmit [an] Application to [Medicare Administrative Contractor] ***to voluntarily terminate Medicare enrollment***" for CCMC "[u]pon completion of emergency department closure[.]" Docket No. 882, at ¶ 32 (emphasis added).

11. On April 23, 2025, the Court entered an order approving the closure of the Pennsylvania Hospitals [Docket No. 1613] (the "Closure Order"). CCMC "ceased providing inpatient services as of May 2, 2025." Compl. at ¶ 21. Suzanne A. Koenig, the patient care ombudsman appointed in these cases, also confirmed that the inpatient and emergency department service line for CCMC "officially closed at 7:00 a.m. (prevailing Eastern Time) on May 1, 2025." Docket No. 2151, Exh. C.

12. CCMC remains permanently closed and through July, the front page of the hospital's website directly led to the following statement:

> ***As of April 30th, 2025, our hospital's emergency room will no longer be seeing new patients. In addition, our physician offices will be closed to all patient visits after close of business on Friday, May 2nd, 2025.***

Crozer-Chester Medical Center Website, https://www.crozerhealth.org/globalassets/crozer-patient-letter.pdf (last visited on July 30, 2025) (attached hereto as **Exhibit B** at 57-59).

13. After CCMC "ceased providing inpatient services on May 2, 2025," Compl. at ¶ 36, the Debtors– instead of voluntarily terminating CCMC's Medicare enrollment as they previously represented to the Court that they would do – continued operating their Pennsylvania ASC/Imaging Sites and billing Medicare as "provider-based" hospital outpatient departments using CCMC's unique Medicare provider number as if CMCC had never closed.[4] *See* Compl. at ¶ 19 (stating the Pennsylvania ASC/Imaging Sites "are currently operated and billed as hospital outpatient departments"); *id.* at ¶ 41 (admitting that they continued to use CCMC's Medicare

[4] A "provider-based entity" means a provider of health care services . . . that is either created by, or acquired by, a main provider for the purpose of furnishing health care services of a different type from those of the main provider under the ownership and administrative and financial control of the main provider . . ." 42 C.F.R. § 413.65(a)(2). Importantly, "all final determinations as to whether particular facilities or organizations are provider-based are to be made by [CMS]." *Id.* Debtors submitted a request that CMS determine that their outpatient facilities be deemed provider-based entities on July 7, 2025, *see supra* ¶ 16, over two months after closing CMCC.

billing number until at least until June 3, 2025, and then allegedly imposed a "voluntary hold on such claims.").

14. On or about May 29, 2025, after disclosing that the Pennsylvania ASC/Imaging Sites were using CCMC's provider number, the Debtors engaged CMS and informally requested that CMS allow the Pennsylvania ASC/Imaging Sites to use CCMC's provider number, "thereby permitting these facilities to bill and collect" from Medicare as if they were hospital-based outpatient departments. Compl. at ¶¶ 33, 34.

15. Pursuant to the Medicare Act, CMS gave notice on June 6, 2025, to the Debtors that CCMC's Medicare provider agreement was terminated effective June 21, 2025, because CMS determined that CCMC was no longer providing inpatient services and therefore no longer eligible to participate in Medicare as a "hospital." *See* Compl.¶36; **Exhibit C** at 61-64, *CMS Notification of Termination* (the "Termination Notice").

16. On July 7, 2025, CCMC initiated the first level of administrative appeal of CMS' termination decision requesting a hearing before an administrative law judge to reconsider CMS's termination decision. *See* July 7, 2025 Request for Hearing to Departmental Appeals Board (attached hereto as **Exhibit D** at 66-74). In its appeal, the Debtors argue that the Pennsylvania ASC/Imaging Sites should qualify as provider-based outpatient departments. *See id.*, at 69-71.

ARGUMENT

I. Count I Must Be Dismissed Because the Court Lacks Subject Matter Jurisdiction to Declare That CMS Unlawfully Issued the Termination Notice and the Debtors Have No Claim that Medicare Receivables are Property of the Estates or that Terminating CCMC's Provider Agreement Violated the Automatic Stay.

17. Count I of the Complaint, while somewhat convoluted, requests the Court enter three separate declaratory judgments: (1) CMS cannot terminate CCMC's Medicare enrollment or

refuse to process post-petition Medicare reimbursement claims submitted by the Pennsylvania ASC/Imaging Sites; (2) CMS' termination of the Medicare provider agreement and any withholding of Medicare reimbursement claims submitted by the Pennsylvania ASC/Imaging Sites violate the automatic stay under § 362(a); and (3) Medicare reimbursement claims constitute a property of the estates under § 541(a). *See* Compl. at ¶ 50. As a general matter, while a declaratory relief is "a matter of [bankruptcy] court discretion," *Torch Inc. v. LeBlanc*, 947 F.2d 193, 194 (5th Cir. 1991), a plaintiff must demonstrate that they are "likely to suffer *future* injury." *Ingle v. Butler*, No. 2:24-CV-140-Z-BR, 2025 WL 1184657, at *7 (N.D. Tex. Apr. 1, 2025); *Stringer v. Whitley*, 942 F.3d 715, 720 (5th Cir. 2019) ("[D]eclaratory relief cannot conceivably remedy any past wrong.") (internal citation omitted). Where the declaratory relief is premised on past acts, a plaintiff must establish "either continuing harm or a real and immediate threat of repeated injury in the future." *Ingle*, 2025 WL 1184657, at *7.

18. Here, Plaintiffs ask the Court to declare that CMS "may not terminate CCMC's Medicare enrollment or refuse to accept and process Medicare [claims] after the Petition Date." Compl. at ¶ 50. But, as Plaintiffs concede, CMS already terminated CCMC's Medicare provider agreement as of June 21, 2025. *See* Compl. at ¶ 48. Plaintiffs also admit that "the Crozer Debtors placed a hold, effective as of June 3, 2025, on new Medicare and Medicaid claims for services furnished after May 1, 2025 at the Pennsylvania ASC/Imaging Sites." Compl. at ¶ 34. Plaintiffs make no allegations that CMS failed to pay any submitted Medicare claims and cannot seek relief of CMS' alleged failure to "accept and process" claims that they have yet to even submit to CMS for review and processing. Thus, Plaintiffs have not "pleaded facts showing a continuing harm or immediate threat of repeated harm." *Ingle*, at *7.

19. Further, the request for declaratory relief under Count I must be dismissed because such relief is inherently duplicative of Counts II and III (damages for violating §§ 362(a) and 525(a), respectively). *See In re Trevino*, 615 B.R. 108, 144 (Bankr. S.D. Tex. 2020) ("[D]ismissal of a declaratory judgment action is warranted where the declaratory relief plaintiff seeks is duplicative of other causes of action."); *8300 Buckeye Delaware LLC v. UPS Supply Chain Sols., Inc.*, 2023 WL 7273712, at *13 (N.D. Tex. Sept. 17, 2023) ("Courts in the Fifth Circuit have declined to adjudicate declaratory judgment actions when the declaration seeks the same relief as other causes of action in the claim."). Because the Court's adjudication of the alleged violations of the automatic stay and discrimination will necessarily determine the relief sought in Count I of the Complaint, the declaratory judgment claims are duplicative and therefore "unavailable as a matter of law." *Vandelay Hosp. Grp. LP v. Cincinnati Ins. Co.*, No. 3:20-CV-1348-D, 2020 WL 4784717, at *7 (N.D. Tex. Aug. 18, 2020) (internal citation omitted).

20. Even, *assuming arguendo*, that declaratory relief is allowed, each of the Plaintiffs' requests, as explained below, fail for lack of subject matter jurisdiction and for failing to state a claim upon which the Court can grant relief.

A. The Court Lacks Subject Matter Jurisdiction to Retroactively Declare that CMS Could Not Terminate CCMC's Medicare Provider Agreement.

21. Plaintiffs specifically request the Court declare that CMS "may not terminate CCMC's Medicare enrollment or refuse to accept and process [claims for] Medicare Reimbursements after the Petition Date." Compl. at ¶ 50. While Plaintiffs' requested relief is framed to enjoin CMS from taking future action, CCMC's enrollment (and CMS' ability to

process claims) was terminated three weeks *before* the Plaintiffs filed their Complaint.[5] *Id.* Plaintiffs are therefore not entitled to a declaratory relief for this alleged past wrong.

22. Regardless, a challenge to CMS' administrative decision to terminate a Medicare provider agreement is a dispute that is necessarily and primarily about "entitlement to benefits" under the Medicare Act. Section 1395cc(h)(1)(A) of Title 42 expressly grants a provider the right to receive administrative and judicial review of the Secretary's decision to terminate a provider's Medicare enrollment "to the same extent as is provided in section 405(b) of this title, and to judicial review of the Secretary's final decision after such hearing ***as is provided in section 405(g) of this title***." (emphasis added). In turn, § 405(g) of Title 42 permits review of the Secretary's "final decision" by filing a civil action within sixty days after the Secretary's decision notice. Notably, the next section of the statute, section 405(h), mandates that section 405(g) is the exclusive vehicle for a court's jurisdiction:

> [1] The findings and decision of the [Secretary] after a hearing shall be binding upon all individuals who were parties to such hearing. [2] ***No findings of fact or decision of the Secretary shall be reviewed by any person, tribunal, or governmental agency except as herein provided.*** [3] No action against the United States, the [Secretary], or any officer or employee thereof shall be brought under section 1331 or 1346 of Title 28 to recover on any claim arising under this subchapter.

42 U.S.C. § 405(h) (emphasis and numerals added). The phrase "herein provided", as it appears in § 405(h), indisputably refers to § 405(g). *See Smith v. Berryhill,* 587 U.S. 471, 475 (2019) ("Congress made clear that review would be available only 'as herein provided'—that is, only under the terms of § 405(g)."); *see also*, *Weinberger v. Salfi,* 422 U.S. 749, 759 (1975) ("Even if

[5] Plaintiffs' related request that the Court declare that CMS cannot "refuse to accept and process" Medicare claims after the Petition Date completely fails as the Plaintiffs never allege, assert or otherwise indicate that CMS has refused to process claims submitted after the Petition Date. The only potential claims raised in the Complaint that CMS could refuse to process are claims by the Pennsylvania ASC/Imaging Sites that Plaintiffs repeatedly assert they never submitted to CMS. *See* Compl. at ¶¶ 34 and 41.

the denial is nonfinal, it is still a 'decision of the Secretary' which, by virtue of the second sentence of [§] 405(h), may not be reviewed save pursuant to [§] 405(g).").

23. As noted by the Fifth Circuit, § 405(h)'s second sentence does two things: "First, it channels claims challenging a certain type of agency decision . . . into § 405(g). Second, it ensures that § 405(g) is the *sole jurisdictional avenue* for the channeled claims." *In re Benjamin,* 932 F.3d 293, 300 (5th Cir. 2019) (emphasis added). In other words, the second sentence imposes an *independent* jurisdictional bar on courts, including bankruptcy courts, for claims and challenges that section 405(g) requires to be channeled through agency review. *Id.* The "types of agency decisions" channeled to the administrative process, the Fifth Circuit continued, were those where a disputed decision is "primarily about . . . entitlement to benefits." *Id.* at 302. If so, the dispute would be channeled into administrative review by section 405(g), with section 405(h) limiting the federal courts' role to reviewing the agency's final decision. *Id.* at 301.

24. The statutory and regulatory provisions governing the termination of CCMC's Medicare provider agreement relate to entitlement to Medicare participation (and therefore entitlement to Medicare payments). Without a provider agreement, CCMC does not have Medicare billing privileges and therefore cannot submit claims to CMS for reimbursement. *See* 42 U.S.C. § 1395cc(a)(1); 42 C.F.R. § 424.505. Therefore, under *Benjamin*, Plaintiffs' request for "a declaration that Defendants may not terminate CCMC's Medicare enrollment or refuse to accept and process Medicare Reimbursement after the Petition Date," Compl. at ¶ 50, is "unquestionably administrative in nature" and a "claim for administrative entitlement." *Affiliated Professional Home Health Care Agency v. Shalala,* 164 F.3d 282, 285-86 (5th Cir. 1999); *see Timberlawn Mental Health System v. Burwell*, 2015 WL 4868842, at *3-4 (N.D. Tex. 2015) (denying a

hospital-plaintiff's a motion for temporary restraining order to prohibit HHS from terminating its Medicare provider agreement because the plaintiff's request to "continue its participation in the Medicare program pending an administrative appeal of CMS' termination decision" falls squarely into the types of issues barred under section 405(h)); *Dallas Healthcare, Inc. v. Health and Human Servs. Com'n,* 921 F.Supp. 426, 429 (N.D. Tex. 1996) ("[T]he issue of whether TDHS applied the proper standard goes directly to Dallas Healthcare's claim of entitlement and is not separate or collateral to the issue being considered on appeal by the Secretary."). Because Plaintiffs have failed to fully exhaust their administrative remedies regarding CMS' termination decision, which is the underlying crux for all the relief requested in Count I, the Court has no jurisdiction to declare that CCMC's provider agreement should be retroactively reinstated or make any other declarations that rely on CMS' termination decision. Accordingly, Count I of the Complaint must be dismissed for lack of subject matter jurisdiction under 28 U.S.C. § 1334.

B. Plaintiffs' Request for a Declaration That "Medicare Reimbursements" Constitute Property of the Estates Under 11 U.S.C. § 541 Is Barred by Sovereign Immunity.

25. "The basic rule of federal sovereign immunity is that the United States cannot be sued at all without the consent of Congress." *Block v. N.D. ex rel. Bd. of Univ. & Sch. Lands*, 461 U.S. 273, 287 (1983). Waivers of sovereign immunity may not be implied. *United States v. Nordic Village Inc.*, 503 U.S. 30, 34 (1992). Any governmental waiver of sovereign immunity must be unequivocal, *Franconia Assocs. v. U.S.*, 536 U.S. 129, 141 (2002), and such waivers are strictly construed, *Lane v. Pena*, 518 U.S. 187, 192 (1996). The plaintiff bears the burden to demonstrate that sovereign immunity has been waived. *See Freeman v. United States*, 556 F.3d 326, 334 (5th Cir. 2009) (in suit against the United States, "Plaintiff[s] bear[ ] the burden of showing Congress's unequivocal waiver of sovereign immunity."). If a plaintiff fails to establish a

waiver of sovereign immunity, the Court lacks subject matter jurisdiction over the action and any of its claims for relief. *United States v. Testan*, 424 U.S. 392, 399 (1976).

26. Here, Plaintiffs seek a declaration that "the Crozer Debtors' right to submit claims and receive Medicare Reimbursements is property of the estates under 11 U.S.C. § 541(a)." Compl. at ¶ 50. Such requested relief, however, is barred by sovereign immunity. Section 106(a)(1) of the Bankruptcy Code enumerates 59 sections of the Bankruptcy Code that Congress elected to abrogate the United States' sovereign immunity. *See* 11 U.S.C. § 106(a)(1). Congress excluded, however, section 541 of the Bankruptcy Code from the abrogation list allowing government defendants such as CMS to assert sovereign immunity in proceedings brought by the estate. *See* 140 Cong. Rec. H10,766 (daily ed. Oct. 4, 1994), *reprinted in* ¶ 106 ("This allows the assertion of bankruptcy causes of action, but specifically excludes causes of action belonging to the debtor that become property of the estate under section 541."). Because Congress did not expressly and plainly waive sovereign immunity for claims under § 541 of the Bankruptcy Code, the Court should dismiss Count I, seeking a declaration that CCMC's "right to submit claims and receive Medicare Reimbursements," constitutes property of the estates. Compl. at ¶ 50.

C. Plaintiffs' Request for a Declaration That "Medicare Reimbursements" Constitute Property of the Estates Under Section 541 of the Bankruptcy Code Must Be Denied for Failure to State a Claim.

27. Even if the Court finds that the above-described sovereign immunity abrogation does not bar the adjudication of the requested relief, the Complaint demonstrably lacks facts supporting a right to relief for a declaration that "Medicare Reimbursements" constitute property of the estates. The bankruptcy estate generally includes "all legal or equitable interests of the debtor in property as of the commencement of the case." 11 U.S.C. § 541(a)(1). Congress

explained that "[t]hough this paragraph will include . . . claims by the debtor against others, it is not intended to expand the debtor's rights against others more than they exist at the commencement of the case." H.R. Rep. No. 95-595, 95th Cong., 1st Sess. 367-68 (1977). In other words, the commencement of the bankruptcy case and automatic stay do not afford the Debtors greater property interests than they had pre-petition. *See Mission Product Holdings, Inc. v. Tempnology, LLC,* 587 U.S. 370, 381 (2019) (acknowledging "general bankruptcy rule" that "[t]he estate cannot possess anything more than the debtor itself did outside bankruptcy.").

28. That principle is fatal to Plaintiffs' contentions. The nature and extent of property rights in bankruptcy are determined by the underlying substantive law. *Raleigh v. Illinois Dep't of Revenue*, 530 U.S. 15, 20 (2000). The underlying federal law applicable here are clear that no provider has any property interest, legitimate expectation, or statutory entitlement to participate in Medicare without meeting fundamental conditions on program eligibility. *See Sahara Health Care, Inc. v. Azar*, 349 F. Supp. 3d 555, 572 (S.D. Tex. 2018), *aff'd*, 975 F.3d 523 (5th Cir. 2020) ("Plaintiff's participation in the Medicare program and related appeals process does not equate to having a property interest in its reimbursement claims."). Only "providers of services" meeting statutory and regulatory conditions of participation are qualified to enter into a provider agreement with CMS and to receive payment for Medicare services. 42 U.S.C. §1395cc(a)(1). And every provider's interests in participating in Medicare are taken subject to the CMS' on-going, statutory authority to terminate the provider agreement if CMS determines that the provider "fails to comply substantially with the provisions of the agreement" or "with the provisions of this [Medicare] title and regulations thereunder." 42 U.S.C. § 1395cc(b)(2)(A). The Debtors, in sum, do not have a cognizable property interest in participating in Medicare without

meeting Medicare's conditions of participation. *See e.g., Shah v. Azar*, 920 F.3d 987, 997-98 (5th Cir. 2019) ("Because health care providers are not the intended beneficiaries of the federal health care programs . . . they therefore do not have a property interest in continued participation or reimbursement."). Because the right to participate in the Medicare Program does not constitute a property interest, Plaintiffs' request for a declaration that they are entitled to submit claims and receive Medicare reimbursements under § 541(a), must be dismissed for failure to state a claim.

D. Plaintiffs' Request for a Declaration that CMS Violated the Automatic Stay for Allegedly Attempting to Recover Unbilled Claims Must Be Denied Because 11 U.S.C. § 362 Cannot Be Used to Liquidate Disputed Claims.

29. The "Crozer Debtors' right to submit claims and receive Medicare Reimbursements" is currently in dispute. Compl. at ¶ 50. Section 362 of the Bankruptcy Code, however, cannot be used to adjudicate claims for property or payments that are in dispute. As one bankruptcy court aptly noted, the "automatic stay, like the turnover provision of the Bankruptcy Code, 11 U.S.C. § 542, cannot be used as a vehicle 'to liquidate contract disputes or otherwise demand assets whose title is in dispute.'" *In re Yelverton*, No. 09-00414, 2014 WL 7141938, at *9 (Bankr. D.D.C. Dec. 12, 2014), *subsequently aff'd sub nom. United States ex rel. Yelverton v. Fed. Ins. Co.*, 831 F.3d 585 (D.C. Cir. 2016) (quoting *United States v. Inslaw, Inc.*, 932 F.2d 1467, 1472 (D.C. Cir. 1991)). A contrary reading "would turn every act of the possessor that implicitly asserts his title over disputed property into a violation of § 362(a)," and "give the bankruptcy court jurisdiction over all such disputes[.]" *Inslaw*, 932 F.2d at 1473.

30. Applying this reasoning here, Congress certainly did not intend the Medicare Trust Fund to be sequestered wholesale by CCMC's bankruptcy estate without any regard for a carefully-crafted administrative review process required under the Medicare Act. The "Medicare

Reimbursements" that the Debtors have yet to bill for but allege CMS is "withholding," Compl. at ¶ 50, are in dispute, as evidenced by the pending administrative appeal commenced by CCMC. Therefore, unless and until the Debtors obtain a favorable decision regarding their request to retroactively use CCMC's provider number through the Medicare administrative process, any "Medicare Reimbursements" are not property of the estates (and therefore CMS cannot violate the automatic stay). Because the Debtors are not entitled to payment for claims that have yet to be submitted and are in dispute, a request for declaration that CMS violated the automatic stay must be denied. *See In re Orthotic Center, Inc*., 193 B.R. 832, 834 (N.D. Ohio 1996) ("the Secretary's suspension of [Medicare] payments was not equivalent to the seizure of property of the estate because the right to receive payments is in dispute, and the payments are not the property of the debtor until the dispute is decided in its favor.").

E. Plaintiffs' Request for a Declaration That CMS Violated the Automatic Stay for Terminating CCMC's Medicare Provider Agreement Must Be Denied for Failure to State a Claim Because the Termination Was an Exercise of CMS' Police and Regulatory Power Under Section 362(b)(4) of the Bankruptcy Code.

31. Plaintiffs allege that CMS' termination of CCMC's Medicare enrollment is a violation of the automatic stay and ask the Court to declare that terminating CCMC's Medicare provider agreement is not excepted under § 362(b)(4). *See* Compl. at ¶¶ 48, 50. As discussed *infra* Section III, CMS' termination of CCMC's Medicare enrollment related solely to its closure as a hospital providing inpatient services. "Case law makes clear that agencies qualify for the police and regulatory exception when they bring actions primarily intended to bring entities into compliance with applicable regulations[.]" *In re FiberTower Network Servs. Corp.*, 482 B.R. 169, 180 (Bankr. N.D. Tex. 2012). In *FiberTower*, the court has interpreted § 362(b)(4) extremely broadly and held that the exception "allows a 'governmental unit' to bring or continue actions

against a debtor to prevent or stop violations of law affecting matters of public health, safety, *or welfare.*" *Id.* (emphasis original); *Parkview Adventist Med. Ctr. v. United States on behalf of Dep't of Health & Hum. Servs.*, 842 F.3d 757, 764 (1st Cir. 2016) (finding that CMS' termination of a hospital's Medicare provider agreement did not violate the automatic stay because it was an exercise of regulatory power under the Medicare statute).

32. Plaintiffs ignore that CMS "does not operate Medicare, ultimately, in [its] own interest." *In re Tri Cnty. Home Health Servs., Inc.*, 230 B.R. 106, 113 (Bankr. W.D. Tenn. 1999). Rather, CMS bears regulatory responsibility for "effective[ly] managing the public funds entrusted to the Medicare program," and it "has a critical interest in maintaining the integrity of the Medicare program for the benefit of all, including the taxpaying public." *Id.* (citation omitted); *see also In re Vitalsigns Homecare, Inc.*, 396 B.R. 232, 239-40 (Bankr. D. Mass. 2008) ("Protecting the public fisc" is fundamental to Medicare's statutory scheme). Because CCMC is no longer a "hospital," the Debtors' receipt of payments from billing the Pennsylvania ASC/Imaging Sites as hospital-based outpatient departments pursuant to CCMC's terminated Medicare provider number compromises the integrity and management of the public funds administered by CMS. CMS thus acted well within its "generally applicable regulatory laws" to ensure that Medicare funds meant for hospitals which primarily service inpatients were not billed for by facilities which solely service outpatients.

33. Further, conditions to participate in the Medicare program—such as providing adequate nursing services, the credentialing and supervision of medical staff, assurance of a safe environment, and adequate infection control—are specifically intended to protect public health and safety and plainly further a vital public interest. *See* 42 U.S.C. § 482.1. Plaintiffs admit they

unilaterally "decided to continue services at the Pennsylvania ACS/Imaging Sites" as hospital outpatient departments, Compl. at ¶ 28, without certifying or complying that these sites meet all necessary regulatory conditions. As explained above, CMS – not the facility – determines whether the facility qualifies as hospital-based facility. *See supra*, fn.4.

34. Where, as here, CMS' regulatory actions intended to bring CCMC into compliance with federal healthcare law, CMS' termination falls squarely within the agency's police and regulatory powers. No more obvious exercise of the government's power to "protect the health, safety, and welfare of the public" can be imagined than CMS' administrative decision here. *FiberTower*, 482 B.R. at 180. Any adverse consequences or alleged harm described in the Complaint is entirely self-inflicted, resulting from Plaintiffs' failure to comply with federal law. As such, Plaintiffs' requested declaration that terminating CCMC's Medicare provider agreement is not excepted under 11 U.S.C. § 362(b)(4) must be denied.

F. Plaintiffs' Request for a Declaration that CMS Violated the Automatic Stay for Allegedly Demanding Payment of Prepetition CMS Obligations Must Be Denied for Failure to State Claim Because Medicare Recoupment Is Not Subject to 11 U.S.C. § 362.

35. Plaintiffs' contention that CMS violated the automatic stay because it made "post-petition demands for payment for pre-petition CMS Obligations," Compl. at ¶ 54, even if taken true as alleged, fails to state a claim upon which relief can be granted. The Complaint defines "CMS Obligations" as "prepetition debts of CCMC to CMS for . . . certain advance payments received from CMS related to the COVID-19 pandemic[.]" Compl. at ¶ 32.[6] CMS has

[6] Further, this Court expressly authorized the Debtors to "pay and honor related prepetition obligations under the Refund Programs" which included the CMS Obligations. *See* Docket No. 604. The Debtors acknowledged that they are "subject to offsets or recoupments for reimbursement of overpayments or payments made . . . including payments made in connection with extended repayment plans with the applicable federal or state agencies overseeing Medicare and Medicaid." Docket No. 10, at ¶ 8. Plaintiffs' argument that CMS violated the stay by allegedly demanding court-

independent statutory and regulatory right to recoup Medicare overpayments and advances. *See* 42 U.S.C. § 1395g(a) and (f)(2)(C); 42 C.F.R. § 405.373(a) and 413.64(g). Courts, including the Fifth Circuit, have held with near unanimity that Medicare recoupment is not subject to the automatic stay. *See Sahara Health Care, Inc. v. Azar*, 975 F.3d 523, 530 (5th Cir. 2020) (". . . Medicare recoupments are not subject to an automatic stay in bankruptcy."); *Mount Sinai Hosp. of Greater Miami, Inc. v. Weinberger*, 517 F.2d 329 (5th Cir. 1975), *modified*, 522 F.2d 179 (5th Cir. 1975) (stating that the government has common law right to recoup from a hospital that received payments for unnecessary medical treatment); *Med-Cert Home Care, LLC v. Azar*, 365 F. Supp. 3d 742, 754-55 (N.D. Tex. 2019) (holding that neither the discharge injunction nor the automatic stay apply to Medicare recoupment); *see also In re AHN Homecare, LLC*, 222 B.R. 804, 812 (Bankr. N.D. Tex. 1998) (finding that the Medicare agreement constituted one transaction for purposes of recoupment and that HHS did not violate automatic stay in recouping from overpayments across cost years).

36. Instead of recognizing CMS' recoupment rights, Plaintiffs attempt to catch the Court's attention by mischaracterizing any alleged Medicare recoupment as "garnish[ment]," Compl. at ¶ 5. Stating that CMS "attempt[ed] to garnish" is a legal conclusion, however, and must be disregarded. *Id.*; *see Papasan v. Allain,* 478 U.S. 265, 286 (1986) (on a motion to dismiss, courts "are not bound to accept as true a legal conclusion couched as a factual allegation."). Plaintiffs have not alleged *any* facts or legal elements to support their claim for unlawful garnishment. *See generally* Compl. As the Fifth Circuit explained, a garnishment requires a "writ

authorized payments of the CMS Obligations is therefore untenable.

of garnishment" served to the "garnishee." *See FG Hemisphere Assocs., LLC v. Republique du Congo*, 455 F.3d 575, 589 (5th Cir. 2006).

37. Plaintiffs offer no allegations that CMS served a writ of garnishment to the Debtors. Not using the word "recoupment" or "recoup" once in the Complaint – whether intentional or unintentional – and instead using eye-catching language such as "garnish[ment]" and "demands" suggests that Plaintiffs know that, as a matter of law, Medicare recoupment is not subject to the automatic stay. Accordingly, the Plaintiffs' allegations that CMS violated the automatic stay by "garnish[ment]" and "demands" to collect pre-petition liabilities do not (and cannot) meet the *Iqbal* and *Twombly* standards and must be dismissed for failure to state a claim.

II. Count II of the Complaint Must Be Dismissed for Failure to State a Claim Upon Which Relief May Be Granted Because Corporate Debtors Are Not Entitled to Damages Under 11 U.S.C. § 362(k).

38. Plaintiffs' cursory request for "actual damages, including costs and attorneys' fees, in accordance with Section 362(k)" lacks any merit. Compl. at ¶ 57. Not only is there no violation of the automatic stay, but section 362(k)(1) of the Bankruptcy Code only permits damages for willful stay violations for "an individual." "Plainly, the statute here is referring only to human beings," rather than "corporations and other legal entities." *In re Chateaugay Corp.*, 920 F.2d 183, 184-85 (2d Cir. 1990) (applying former Section 362(h), now recodified at Section 362(k)(1)); *see also In re Roxwell Performance Drilling, LLC*, No. 13-50301-RLJ-11, 2014 WL 2800767, at *4 (Bankr. N.D. Tex. June 19, 2014) ("As Roxwell is not an individual, it may not recover damages under § 362(k)."); *In re San Angelo Pro Hockey Club, Inc.*, 292 B.R. 118, 124 (Bankr. N.D. Tex. 2003) ("As conceded by the parties here, the Debtor, as a corporation, may not recover damages under section 362(h)"); *In re Freemyer Indus. Pressure, Inc.*, 281 B.R. 262, 268

(Bankr. N.D. Tex. 2002) ("Though the case law is mixed, the better view is that section 362(h) may only be invoked by individuals. This Court, per Steven A. Felsenthal, J., has held that relief under section 362(h) is limited to individuals.") (internal citation omitted); *In re First RepublicBank Corp.*, 113 B.R. 277, 279 (Bankr. N.D. Tex. 1989) ("This court respectfully disagrees with those courts which have applied § 362(h) to corporations."). CCMC is not an "individual" capable of receiving damages for automatic stay violations. Accordingly, Plaintiffs' request in Count II for damages under Section 362(K) fails to state a claim for relief upon which relief may be granted and must be denied.

III. Count III Must Be Dismissed Because CMS' Termination of CCMC's Medicare Enrollment Was Not Discriminatory Under 11 U.S.C. § 525(a).

39. Plaintiffs seek "actual damages … in an amount to be proven at trial", stating that "termination of CCMC's Medicare enrollment and threats of monetary penalties are discriminatory acts taken solely because the Crozer Debtors are debtors under title 11[.]" Compl. at ¶¶ 60, 62. This mere recitation of § 525 is insufficient to show that Plaintiffs are entitled to damages under § 525. *See Lormand v. US Unwired, Inc.*, 565 F.3d 228, 257 (5th Cir. 2009) ("[T]he pleading must contain something more . . . than . . . a statement of facts that merely creates a suspicion [of] a legally cognizable right of action.") (internal citation omitted).

40. As explained earlier, any potential damages would arise from alleged claims related to services provided by the Pennsylvania ASC/Imaging Sites after CMCC closed. These alleged claims, and any potential amounts due, are solely within the exclusive jurisdiction of the Secretary to adjudicate. 42 U.S.C. § 405(h), (g); *Matter of Benjamin,* 932 F.3d 293, 300 (5th Cir. 2019). Moreover, under the plain language of the statute, the Court must dismiss Count III of the Complaint because the undisputed facts cannot support Plaintiffs' allegations that CMS

terminated CCMC's Medicare provider agreement "solely because" of CCMC's bankruptcy filing. 11 U.S.C. § 525(a) ("[A] governmental unit may not deny, revoke, suspend, or refuse to renew a license, . . . or other similar grant . . . ***solely because*** such bankrupt or debtor is or has been a debtor under this title. . . .") (emphasis added); *see e.g., Devon Enters., L.L.C. v. Arlington Indep. Sch. Dist.*, 541 F. App'x 439, 442 (5th Cir. 2013) (a violation under § 525(a) requires a showing that the government's "decision was made and that the filing of a bankruptcy was the ***sole reason*** for the decision.") (emphasis added). As the Supreme Court emphasizes, "Section 525 means nothing more or less" than that an entity's status as a debtor in bankruptcy "***must alone be the proximate cause*** . . . [and] the act or event that triggers the agency's decision" in order to constitute proscribed conduct. *F.C.C. v. NextWave Pers. Commc'ns Inc.*, 537 U.S. 293, 301-02 (2003) (emphasis added).

41. A case from the First Circuit is particularly instructive here. In *Parkview Adventist Med. Ctr. v. Dep't of Health & Hum. Servs.*, 842 F.3d 757 (1st Cir. 2016), the First Circuit held that CMS' termination of a hospital's provider agreement did not violate 11 U.S.C. § 525(a), because there was "nothing in the termination decision that depended upon [the debtor's] insolvency or bankruptcy petition." *Id.* at 765. There, CMS issued a termination letter to the debtor-hospital stating that it was terminating the debtor's provider agreement because the debtor "had decided to close its inpatient facilities and thereby had ceased to qualify as a hospital under the Medicare statute." *Parkview Adventist*, 842 F.3d at 765. The court found that the "termination decision involved no forbidden discrimination based on insolvency." *Id.*

42. Similarly, Plaintiffs acknowledge that CMS terminated CCMC's Medicare provider agreement because "CMS has determined that CCMC is not in compliance with the

applicable Medicare statutory and regulatory provisions[.]" Compl. at ¶ 36 (directly quoting the Termination Notice). The reality is CMS terminated CCMC's Medicare provider agreement because CCMC publicly admitted on its own website and in court filings that it was closing its doors and would no longer operate as a hospital. The Debtors even represented that they themselves would terminate CCMC's enrollment once it closed its emergency department. Thus, CMS' termination had *nothing* to do with CCMC's bankruptcy filing, but *everything* to do with CCMC's closure as a Medicare-provider hospital. Accordingly, there are no facts or allegations that can support the notion that CMS terminated CCMC's Medicare provider agreement "solely because" of its bankruptcy filing as required for a § 525(a) violation.

CONCLUSION

Therefore, based on the foregoing, the United States respectfully requests that the Court enter an order granting the Motion, dismissing all Counts in the Complaint, and granting the United States such other and further relief as is just and proper.

Dated: August 19, 2025

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on August 19, 2025, a true and correct copy of the foregoing was served via electronic means through transmission facilities from the Court upon those parties authorized to participate and access the Electronic Filing System in the above-captioned case.

Dated: August 19, 2025

/s/ Jae Won Ha
JAE WON HA